CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Hospital and Provider Operations

(Amended after Comments)

907 KAR 1:015. Payments for outpatient hospital [~~outpatient~~] services.

RELATES TO: KRS 205.520, 216.380, 42 C.F.R. **400.203,** 440.2, 440.20(a), 447.321, 42 USC 1395l(h)**, 1396r-8(a)(7)**

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 205.637, 42 U.S.C. 1396a, 1396b, 1396d

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has the responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method for determining amounts payable by the Medicaid Program for outpatient hospital [~~outpatient~~] services.

Section 1. Definitions. (1) "Critical access hospital" or "CAH" means a hospital meeting the licensure requirements established in 906 KAR 1:110 and KRS 216.380.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) **"Federal financial participation" is defined in 42 CFR 400.203.**

(4) "Finalized" means approved or final as determined by the Centers for Medicare

and Medicaid Services (CMS).

(5)[~~(4)~~] "Outpatient cost-to-charge ratio" means the ratio determined by dividing the costs reported on Supplemental Worksheet E-3, Part III, Page 12 column 2, line 27 of the cost report by the charges reported on column 2, line 20 of the same schedule.

Section 2. In-State Outpatient Hospital Service Reimbursement. (1)(a) Except for critical access hospital services and outpatient hospital laboratory services, the department shall reimburse on an interim basis for in-state outpatient hospital services at a facility specific outpatient cost-to-charge ratio based on the facility's most recently filed cost report.

(b) An outpatient cost-to-charge ratio shall be expressed as a percent of the hospital's charges.

(2) A facility specific outpatient cost-to-charge ratio paid during the course of a hospital's fiscal year shall be designed to result in reimbursement, at the hospital's fiscal year end, equaling **ninety-two (92) [~~ninety (90)~~]** percent of a facility's total outpatient costs incurred during the hospital's fiscal year.

(3) Except as established in subsection (4) of this section:

(a) Upon **reviewing [~~approving~~]** an in-state outpatient hospital's as submitted cost report for the hospital's fiscal year, the department shall preliminarily settle reimbursement to the facility equal to **ninety-two (92) [~~ninety (90)~~]** percent of the facility's total outpatient costs**, excluding laboratory services,** incurred in the corresponding fiscal year; and

(b) Upon receiving **and reviewing** an in-state outpatient hospital's finalized cost report for the hospital's fiscal year, the department shall settle final reimbursement**, ex-**

cluding laboratory services, to the facility equal to **ninety-two (92) [~~ninety (90)~~]** percent of the facility's total outpatient costs incurred in the corresponding fiscal year.

(4)(a) Under no circumstances shall the department's total reimbursement for outpatient hospital services exceed the aggregate limit established in 42 C.F.R. 447.321.

(b) If projections indicate for a given state fiscal year that reimbursing for outpatient hospital services at **ninety-two (92) [~~ninety (90)~~]** percent of costs would result in the department's total outpatient hospital service reimbursement exceeding the aggregate limit established in 42 CFR 447.321, the department shall proportionately reduce final outpatient hospital service reimbursement for each hospital to equal a percent of costs which shall result in total outpatient hospital reimbursement equaling the aggregate limit established in 42 CFR 447.321.

(5) In accordance with 42 USC 1396r-8(a)(7), a hospital shall include the corresponding healthcare common procedure coding (HCPC) code when billing a revenue code of 250 through 261 or 634 through 636 for an outpatient hospital service.

Section 3. Out-of-State Outpatient Hospital Service Reimbursement. Excluding services provided in a critical access hospital **and laboratory services**, reimbursement for an outpatient hospital service provided by an out-of-state hospital shall be **ninety-two (92) [~~ninety (90)~~]** percent of the average in-state outpatient hospital cost-to-charge ratio.

Section 4. Critical Access Hospital Outpatient Service Reimbursement. (1) The department shall reimburse for outpatient hospital services in a critical access hospital as established in 42 CFR 413.70(b) through (d).

(2) A critical access hospital shall comply with the cost reporting requirements established in Section **6[~~3~~]** of this administrative regulation.

Section 5. Outpatient Hospital Laboratory Service Reimbursement. **(1)** The department shall reimburse for an in-state or out-of-state outpatient hospital laboratory service:

(a)[~~(1)~~] A rate equal to sixty-two (62) percent of the Medicare fee schedule rate if a Medicare rate exists for the service; or

(b)[~~(2)~~] By multiplying the facility's current outpatient cost-to-charge ratio by its billed **laboratory** charges if no Medicare rate exists for the service.

(2) Laboratory service reimbursement, in accordance with subsection (1) of this section, shall be:

(a) Final; and

(b) Not settled to cost.

(3) An outpatient hospital laboratory service shall be reimbursed in accordance with this section of this administrative regulation regardless of whether the service is performed in an emergency room setting or in a non-emergency room setting.

Section 6. Cost Reporting Requirements. (1) An in-state outpatient hospital participating in the Medicaid program shall submit to the department a copy of the Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1 and the Supplemental Medicaid Schedule KMAP–4 as follows:

(a) A cost report shall be submitted:

1. For the fiscal year used by the hospital; and

2. Within five (5) months after the close of the hospital's fiscal year; and

(b) Except as follows, the department shall not grant a cost report submittal extension:

1. The department shall grant an extension if an extension has been granted by Medicare. If an extension has been granted by Medicare, when the facility submits its cost report to Medicare it shall simultaneously submit a copy of the cost report to the department; or

2. If a catastrophic circumstance exists, as determined by the department (for example flood, fire, or other equivalent occurrence), the department shall grant a thirty (30) day extension.

(2) If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.

(3) If a cost report indicates payment is due **by a hospital to the department, the hospital[~~, a provider~~]** shall submit the amount due or submit a payment plan request with the cost report.

(4) If a cost report indicates a payment is due **by a hospital to the department and the [~~and a~~]** hospital fails to remit the amount due or request a payment plan, the department shall suspend future payment to the hospital until the hospital remits the payment or submits a request for a payment plan.

(5) An estimated payment shall not be considered payment-in-full until a final determination of cost has been made by the department.

(6) A cost report submitted by a hospital to the department shall be subject to departmental audit and review.

(7) Within seventy (70) days of receipt from the Medicare intermediary, a hospital shall submit to the department a printed copy of the final Medicare-audited cost report including adjustments.

(8)(a) If it is determined that an additional payment is due **by a hospital** after a final determination of cost has been made by the department, the additional payment shall be due **by the hospital to the department within** sixty (60) days after notification.

(b) If a hospital does not submit the additional payment within sixty (60) days, the department shall withhold future payment to the hospital until the department has collected in full the amount owed by the hospital to the department.

Section 7. **Federal Financial Participation. A provision established in this administrative regulation shall be effective contingent upon the department's receipt of federal financial participation for the respective provision.**

Section 8. Appeals. A hospital may appeal a decision by the department regarding the application of this administration regulation in accordance with 907 KAR 1:671.

Section **9.[~~8.~~]** Incorporation by Reference. (1) The following material is incorporated by reference into this administrative regulation:

(a) "Supplemental Worksheet E-3, Part III, Page 12, May 2004 edition";

(b) "Supplemental Medicaid Schedule KMAP-1"; May 2004 edition; **[~~and~~]**

(c) "Supplemental Medicaid Schedule KMAP-4", May 2004 edition**; and**

(d) "Supplemental Medicaid Schedule KMAP-6", January 2007 edition.

(2) The material listed in subsection (1) of this section may be inspected, copied, or

obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40601, Monday through Friday 8 am to 4:30 pm. [~~"Current procedural terminology code" or "CPT code" means a code used for the reporting of medical services or procedures using the current procedural terminology developed by the American Medical Association.~~

~~(3) "Department" means the Department for Medicaid Services or its designee.~~

~~(4) "Healthcare common procedure coding system" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services that represent procedures.~~

~~(5) "Level 1 service" means services billed using CPT code 99281.~~

~~(6) "Level 2 service" means services billed using CPT codes 99282 or 99283.~~

~~(7) "Level 3 service" means services billed using CPT codes 99284, 99285, 99291, or 99292.~~

~~(8) "Outpatient cost-to-charge ratio" means the ratio determined by dividing the costs reported on Supplemental Worksheet E-3, Part III, Page 12 column 3, line 27 of the cost report by the charges reported on column 3, line 20 of the same schedule.~~

~~(9) "Revenue code" means a provider-assigned revenue code for each cost center for which a separate charge is billed.~~

~~(10) "Triage" means a medical screening and assessment billed using revenue code 451.~~

~~Section 2. Outpatient Hospital Services. (1) Except for a critical access hospital, for services provided on or after August 4, 2003, the Department for Medicaid Services shall reimburse a participating in-state hospital for outpatient services in accordance~~

with this subsection.

(a) For the following procedures, the rates shall be as follows:

1. Cardiac catheterization lab:

a. Unilateral - $1,478; or

b. Bilateral - $1,770;

2. Computed tomography scan - $479;

3. Lithotripsy - $3,737;

4. Magnetic resonance imaging - $593;

5. Observation room - $458; and

6. Ultrasound - $177.

(b) If multiple services listed in paragraph (a) of this subsection are provided, each service shall receive the corresponding rate established in paragraph (a) of this subsection.

(c) The department shall utilize the 1996 Medicare ambulatory surgical center groups to reimburse for an outpatient surgery. The following chart establishes the reimbursement rate for each corresponding surgical group:

Ambulatory Surgical Center Group	Reimbursement Rate
Group 1	$397
Group 2	$534
Group 3	$610
Group 4	$753
Group 5	$858

~~Group 6~~	~~$1,016~~
~~Group 7~~	~~$1,191~~
~~Group 8~~	~~$1,191~~

~~(d) Reimbursement for an outpatient surgery which does not have a surgical group rate shall be at a facility-specific outpatient cost-to-charge ratio.~~

~~(e) For multiple surgeries provided to the same recipient on the same day, only the surgery with the highest reimbursement rate established in paragraph (c) of this sub-section, shall be paid.~~

~~(f) Except for the services listed in paragraph (g) of this subsection, all other services provided to the same recipient on the same day shall be reimbursed in accordance with paragraphs (a), (b), (c), (d), and (e) of this subsection.~~

~~(g) The following shall be reimbursed on an interim basis at a facility-specific outpatient cost-to-charge ratio for the following revenue codes:~~

~~Service~~	~~Revenue Code~~
~~Pharmacy~~	~~250, 251, 252, 254, 255, 258, 260, 261, 634, 635, 636~~
~~X-ray~~	~~320, 321, 322, 323, 324, 342, 400, 403, 920~~
~~Supplies~~	~~270, 271, 272, 274, 275, 621, 622, 623~~
~~EKG/ECG and Therapeutic Services~~	~~410, 412, 413, 420, 421, 422, 423, 424, 440, 441, 442, 443, 460, 470, 471, 472, 480, 482, 510, 512, 516, 517, 730, 731, 732, 740, 901,~~

	922, 940, 942, 943
Room and Miscellaneous	280, 290, 370, 371, 372, 374, 700, 710, 750, 761, 890, 891, 892, 893, 921
Dialysis	821, 831, 841
Chemotherapy	330, 331, 332, 333, 334, 335

(h) Services reimbursed in accordance with paragraph (g) of this subsection shall be settled to cost at year end.

(2) Except for pharmacy services billed using revenue codes 250, 251, 252, 254, 255, 258, 260, 261, 634, 634, or 636, medical or surgical supplies billed using revenue codes 270-275, and triage billed using revenue code 451, a hospital shall include all applicable CPT and HCPCS codes on a claim.

(3) Except for services listed in subsection (1)(g) of this section, beginning August 4, 2003, an out-of-state hospital providing outpatient services shall be reimbursed in accordance with subsection (1) of this section.

(4) Services listed in subsection (1)(g) of this section provided by an out-of-state hospital shall be reimbursed by multiplying the average outpatient cost-to-charge ratio of in-state hospitals, excluding critical access hospitals, by billed charges.

(5)(a) An outpatient hospital laboratory service shall be reimbursed at the Medicare-established technical component rate in accordance with 907 KAR 1:029.

(b) An outpatient hospital laboratory service with no established Medicare rate shall be reimbursed by multiplying a facility-specific outpatient cost-to-charge ratio by billed charges.

~~(6) A critical access hospital shall be reimbursed on an interim basis:~~

~~(a) By multiplying charges by the lesser of:~~

~~1. The Medicare cost-to-charge ratio issued by the Medicare fiscal intermediary in effect at the time; or~~

~~2. The Medicaid outpatient cost-to-charge ratio;~~

~~(b) For a laboratory service in accordance with the Medicare fee schedule; and~~

~~(c) With a settlement to cost at the end of the year.~~

~~(7) A hospital providing outpatient services shall be required to submit a cost report within five (5) months after a hospital's fiscal year end.~~

~~(8) Failure to provide a cost report within the timeframe established in subsection (7) of this section shall result in a suspension of future payment until the cost report is received by the department.~~

~~(9) If a cost report indicates payment is due, a provider shall remit payment in full or a request for a payment plan with the cost report.~~

~~(10) If a cost report indicates a payment is due and a hospital fails to remit a payment or request for a payment plan, the department shall suspend future payment to the hospital.~~

~~(11) An estimated payment shall not be considered payment-in-full until a final determination of cost has been made by the department.~~

~~(12) If it is determined that an additional payment is due after a final determination of cost has been made by the department, the additional payment shall be due sixty (60) days after notification.~~

~~(13) If a hospital fails to submit an additional payment in accordance with subsection~~

~~(12) of this section, the department shall suspend future payment to the hospital.~~

~~Section 3. Supplemental Payments. (1) In addition to a payment received in accordance with Section 2 of this administrative regulation, a nonstate government hospital, as defined in 42 C.F.R. 447.321(2), whose county has entered into an intergovernmental agreement with the Commonwealth shall receive a quarterly supplemental payment in an amount equal to the difference between the payments made in accordance with Sections 2 and 4 of this administrative regulation and the maximum amount allowable under 42 C.F.R. 447.321.~~

~~(2) A payment made under this section shall:~~

~~(a) Not be subject to the cost-settlement provisions established in Section 2 of this administrative regulation; and~~

~~(b) Apply to a service provided on or after April 2, 2001.~~

~~Section 4. In-state and Out-of-state Emergency Room Services. (1) Services provided in an emergency room shall be reimbursed as follows:~~

~~(a) The triage service reimbursement rate shall be twenty (20) dollars;~~

~~(b) The level 1 service reimbursement rate shall be eighty-two (82) dollars;~~

~~(c) The level 2 service reimbursement rate shall be $164; and~~

~~(d) The level 3 service reimbursement rate shall be $264.~~

~~(2) In addition to the rate paid for services listed in subsection (1) of this section, the following shall be paid at the following rates:~~

~~(a) Cardiac catheterization lab:~~

~~1. Unilateral - $1,478; or~~

~~2. Bilateral - $1,770;~~

~~(b) Computed tomography scan - $479;~~

~~(c) Lithotripsy - $3,737;~~

~~(d) Magnetic resonance imaging - $593;~~

~~(e) Observation room - $458; and~~

~~(f) Ultrasound - $177.~~

~~(3) If multiple services listed in subsection (2) of this section are provided, each service shall receive the corresponding rate established in subsection (2) of this section.~~

~~(4) Except as listed in subsection (5) of this section, a separate payment shall not be made for the services or supplies listed in Section 2(1)(g) of this administrative regulation.~~

~~(5) A thrombolytic agent shall be reimbursed at the hospital's acquisition cost.~~

~~(6) A service provided in an emergency room of a critical access hospital shall be reimbursed in accordance with Section 2(6) of this administrative regulation.~~

~~Section 5. Appeals. A hospital may appeal a decision as permitted by 907 KAR 1:671.~~

~~Section 6. Incorporation by Reference. (1) "Supplemental Worksheet E-3, Part III, Page 12, November 1992 edition" is incorporated by reference.~~

~~(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40601, Monday through Friday 8 am to 4:30 pm.~~]

907 KAR 1:015
(Amended after Comments)

REVIEWED:

Date

Elizabeth A. Johnson, Commissioner
Department for Medicaid Services

APPROVED:

Date

Janie Miller, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:015
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Darlene Burgess (502) 564-6511 or Stuart Owen (502) 564-6204

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the reimbursement methodology for outpatient hospital services.
(b) The necessity of this administrative regulation: This administrative regulation is necessary in order to reimburse hospitals for the provision of outpatient services.
(c) How this administrative regulation conforms to the content of the authorizing statutes: The authorizing statutes of this administrative regulation grant the Department for Medicaid Services (DMS) the authority to reimburse hospitals for the provision of outpatient services.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation establishes the reimbursement methodology for outpatient hospital services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: DMS is implementing a cost-based reimbursement which will consist of a facility-specific cost to charge ratio on an interim basis followed by a preliminary settlement and final settlement. Initially, DMS proposed settling to ninety (90) percent of costs but as a result of further analysis (and via this amendment after comments) DMS is elevating the settlement to ninety-two (92) percent of costs. Other amendments include: eliminating flat rates for emergency room care; removing ambulatory surgical center care reimbursement provisions from this administrative regulation as ambulatory surgical care reimbursement is addressed in 907 KAR 1:008; noting that reimbursement shall not exceed the federal limit which is established in 42 CFR 447.321. The amendment after comments clarifies various existing policies, establishes that policies are contingent upon the provision of federal financial participation to the department, and adds a form to the material incorporated by reference. Outpatient services in a critical access hospital will continue to be reimbursed as mandated in federal regulation.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to replace the existing diverse and complex reimbursement methodology with a facility-specific reimbursement model equal to ninety-two (92) percent of a facility's costs after settlement. Additionally, the amendment deletes ambulatory surgical center reimbursement provisions as

those are established in 907 KAR 1:008. The reimbursement model established via the amendment complies with the federal law, 42 USC 1396a(a)(30), imposed on state Medicaid programs which requires state Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." The amendment after comments is necessary to clarify existing policy as well as to maintain the viability of the Medicaid program by clarifying that policies are contingent upon the provision of federal financial participation by the Centers for Medicare and Medicaid Services (CMS) to the department. CMS provides approximately seventy (70) of program funding to the department - compared to fifty (50) percent of administrative funding. The department, as part of its mission to serve the citizens of the Commonwealth of Kentucky in a fiscally responsible manner, must strive to ensure that program policies are contingent upon receipt of federal funding. Failure to maintain this safe guard would jeopardize the health, safety and welfare of recipients of Medicaid program services as well as impose an injurious and unsound financial burden on the citizens of Kentucky.

(c) How the amendment conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing a facility-specific reimbursement resulting in a final settlement equal to ninety-two (92) percent of a facility's cost. Additionally, the amendment conforms to the authorizing statutes by eliminating ambulatory surgical center reimbursement provisions as they are established in 907 KAR 1:008, clarifying existing policy, and by rendering policies contingent upon federal financial participation in order to comply with KRS 205.520(3).

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statues by establishing a facility specific reimbursement methodology resulting in a final settlement equal to ninety-two (92) percent of a facility's costs. Additionally, the amendment will assist in the effective administration of the authorizing statutes by eliminating ambulatory surgical center reimbursement provisions as those provisions are established in 907 KAR 1:008, clarifying policy and by rendering policies contingent upon federal financial participation in order to comply with KRS 205.520(3).

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect all hospitals providing outpatient services.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the

change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Outpatient facilities will continue to have to submit cost reports; however, the cost report will now be the primary basis for their reimbursement. Regulated entities will not have to take additional action as a result of the amendment after comments.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This amendment and the amendment after comments do not impose a cost on regulated entities; however, DMS expects in aggregate to realize savings from the amendment. DMS anticipates that some outpatient hospitals will receive an increase in reimbursement as a result of the amendment and that others will receive a decrease in reimbursement. The reimbursement established in this administrative regulation is reasonable, just, complies with federal requirements and is the product of careful analysis.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Outpatient facilities should benefit by receiving an interim reimbursement more closely coinciding with ninety-two (92) percent of their actual costs which in turn should result in less money owed or due at final cost settlement. The initial amendment proposed a settlement to ninety (90) percent of costs; however, DMS is elevating the settlement to ninety-two (92) percent via the amended after comments administrative regulation. Analysis subsequent to the initial amendment indicates that a ninety (90) percent settlement may result in a reimbursement decrease; thus, DMS is elevating the settlement to ninety-two (92) percent of costs.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS initially proposed that a settlement to ninety (90) percent of costs would be budget neutral. Subsequent to the initial amendment, analysis indicated that ninety (90) percent of costs may prove a decrease in reimbursement and, thus, not be budget neutral. Consequently, DMS is elevating the cost settlement to ninety-two (92) percent of costs. The issue is clouded by the fact that costs reports available to DMS do not capture all costs as the prior methodology was partly cost-based and partly flat rate-based. As the flat rate components were not captured on cost reports, DMS and the agents with whom it employs to perform reimbursement calculations and analysis, relied on other data sources to complete the outpatient hospital cost portrait. A graphically clear picture will not be available until after a full year of cost reports, under the new methodology, are available. Future analysis may reveal that reimbursing at ninety-two (92) percent of costs exceeds budget neutrality. If this occurs, DMS may move, via a future amendment, to lower the settlement percent accordingly. Additionally, DMS notes that costs typically increase; thus, a fixed percent of rising costs would result in a monetary increase for facilities. DMS intends to actively monitor and analyze the conse-

quences of the new proposed methodology.

(b) On a continuing basis: DMS initially proposed that a settlement to ninety (90) percent of costs would be budget neutral. Subsequent to the initial amendment, analysis indicated that ninety (90) percent of costs may prove a decrease in reimbursement and, thus, not be budget neutral and DMS is elevating the cost settlement to ninety-two (92) percent of costs. The issue is clouded by the fact that costs reports available to DMS do not capture all costs as the prior methodology was partly cost-based and partly flat rate-based. As the flat rate components were not captured on cost reports, DMS and the agents with whom it employs to perform reimbursement calculations and analysis, relied on other data sources to complete the outpatient hospital cost portrait. A graphically clear picture will not be available until after a full year of cost reports, under the new methodology, are available. Future analysis may reveal that reimbursing at ninety-two (92) percent of costs exceeds budget neutrality. If this occurs, DMS may move, via a future amendment, to lower the settlement percent accordingly. Additionally, DMS notes that costs typically increase; thus, a fixed percent of rising costs would result in a monetary increase for facilities. DMS intends to actively monitor and analyze the consequences of the new proposed methodology.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The amendment, including the amendment after comments, does not establish any fees, nor does it directly or indirectly increase any fees

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment, including the amendment after comments, does not establish or increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Critical access outpatient hospital reimbursement differs from other outpatient hospital reimbursement as critical access hospital reimbursement is established in federal regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:015 Contact Person: Darlene Burgess (502) 564-6511 or Stuart Owen (502) 564-6204

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

   Yes _X_ No ____
   If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? All hospitals providing outpatient hospital services including the county and state owned are affected by this amendment.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 205.520, KRS 194A.030, 194A.050, 205.560, 205.637, 42 U.S.C. 1396a, 1396b, 1396d, 1396r-8(a), 42 CFR 400.203, 440.20, and 42 CFR 447.321.

4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate additional revenue for state or local governments during the first year of implementation.

   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment is not expected to generate additional revenue for state or local governments during subsequent years of implementation.

   (c) How much will it cost to administer this program for the first year? DMS initially proposed that a settlement to ninety (90) percent of costs would be budget neutral. Subsequent to the initial amendment, analysis indicated that ninety (90) percent of costs may prove a decrease in reimbursement and, thus, not be budget neutral. Consequently, DMS is elevating the cost settlement to ninety-two (92) percent of costs. The issue is clouded by the fact that costs reports available to DMS do not capture all costs as the prior methodology was partly cost-based and partly flat rate-based. As the flat rate components were not cap-

tured on cost reports, DMS and the agents with whom it employs to perform reimbursement calculations and analysis, relied on other data sources to complete the outpatient hospital cost portrait. A graphically clear picture will not be available until after a full year of cost reports, under the new methodology, are available. Future analysis may reveal that reimbursing at ninety-two (92) percent of costs exceeds budget neutrality. If this occurs, DMS may move, via a future amendment, to lower the settlement percent accordingly. Additionally, DMS notes that costs typically increase; thus, a fixed percent of rising costs would result in a monetary increase for facilities. DMS intends to actively monitor and analyze the consequences of the new proposed methodology.

(d) How much will it cost to administer this program for subsequent years? DMS initially proposed that a settlement to ninety (90) percent of costs would be budget neutral. Subsequent to the initial amendment, analysis indicated that ninety (90) percent of costs may prove a decrease in reimbursement and, thus, not be budget neutral. Consequently, DMS is elevating the cost settlement to ninety-two (92) percent of costs. The issue is clouded by the fact that costs reports available to DMS do not capture all costs as the prior methodology was partly cost-based and partly flat rate-based. As the flat rate components were not captured on cost reports, DMS and the agents with whom it employs to perform reimbursement calculations and analysis, relied on other data sources to complete the outpatient hospital cost portrait. A graphically clear picture will not be available until after a full year of cost reports, under the new methodology, are available. Future analysis may reveal that reimbursing at ninety-two (92) percent of costs exceeds budget neutrality. If this occurs, DMS may move, via a future amendment, to lower the settlement percent accordingly. Additionally, DMS notes that costs typically increase; thus, a fixed percent of rising costs would result in a monetary increase for facilities. DMS intends to actively monitor and analyze the consequences of the new proposed methodology.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): ____

Expenditures (+/-): ____

Other Explanation: No additional expenditures are necessary to implement this amendment.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:015 Contact Person: Darlene Burgess (502) 564-6511
or Stuart Owen (502) 564-6204

1. Federal statute or regulation constituting the federal mandate.
42 CFR 440.20 and 42 CFR 447.321 address outpatient hospital reimbursement provisions. 42 CFR 400.203 establishes a provision regarding procedure coding.

2. State compliance standards.
KRS 205.520 authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.560 addresses Medicaid reimbursement. KRS 205.637 addresses Medicaid reimbursement to county-owned and operated hospitals. KRS 205.520(3) states, “Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate.
42 USC 1396a(30)(A) requires a state to “provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” Additionally, 42 CFR 447.321 establishes the upper payment limit for outpatient hospital reimbursement.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?
This amendment does not impose stricter requirements than the federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.
This amendment does not impose stricter requirements than the federal requirements.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:015, Payments for Outpatient Hospital Services

Summary of Material Incorporated by Reference

(1) "Supplemental Worksheet E-3, Part III, Page 12 and 13", May 2004 is incorporated by reference and used to document cost reported on covered services on the supplemental worksheet. Previously a November 1992 version was incorporated by reference. The form consists of two (2) pages.

(2) The "Supplemental Medicaid Schedule KMAP-1"; May 2004 edition is incorporated by reference and used to document hospital costs, legal fees, political contributions and out-of-state travel. The form consists of two (2) pages.

(3) The "Supplemental Medicaid Schedule KMAP-4", May 2004 edition is incorporated by reference and used to document miscellaneous care or related including whether non-emergency obstetric services are offered, age threshold (under or over eighteen (18)) of predominant number of individuals served, Medicaid revenues, total revenues, state and local government revenues, charges attributable to charity care, and total inpatient charges. The form consists of one (1) page.

(4) The "Supplemental Medicaid Schedule KMAP-6", January 2007 edition is a new form incorporated by reference used to document labor and delivery room days for a facility. The form consists of one (1) page.

A total of six (6) pages are incorporated by reference into this administrative regulation.